MONTANA MEDICAID PASSPORT To HEALTH
REFERRAL FORM

•Please Do Not Attach This Form To Claim; Retain With Patient Records To Document Referral

PASSPORT Provider's Name & Phone

Patient's Name: _____

Patient's ID Number: _____

Date of Birth: _____

Referred to:

Name of provider_____

Specialty_____Phone Number_____

Diagnosis/problem: _____

_____

Services Requested:
(Please check all that apply)

1. _____ Evaluate and recommend treatment (1 visit)
2. _____ Initiate treatment and refer back to me (2-3 visits)
3. _____ Continued Supervision (Circle number of visits: 4 5 6)
4. _____ Length of Referral
   _____ 15 days _____ 30 days _____ 45 days _____ other (please specify)
5. _____ Specific Procedures _____
6. _____ Surgery (Please Specify)_____
   _____
7. _____ Other _____

Limitations (Please Specify): _____

Follow-up Instructions:_____

Remarks: _____

_____ _____ _____
PASSPORT PROVIDER SIGNATURE AUTHORIZATION # DATE REFERRAL AUTHORIZED

NOTE:
- **IN ALL CASES, COMMUNICATE YOUR ASSESSMENT AND RECOMMENDATION BACK TO THE PASSPORT PROVIDER**
- **IF SERVICES BEYOND THOSE AUTHORIZED ARE NEEDED, CALL PASSPORT PROVIDER**